

iCaSH Norfolk Sexual Wellbeing Service

Referral Criteria

This service provides education, emotional support and behaviour change strategies. We do not currently offer counselling / psychosex counselling.

Inclusion Criteria (low level and / or <6/12 duration)	Exclusion Criteria
• Low or fluctuating desire (not trauma-related) • Arousal difficulties (situational or mild) • Situational erectile difficulties (performance anxiety or stress-related) • Early onset vaginismus / dyspareunia (not chronic) • Performance anxiety • Body-image related sexual concerns • Communication difficulties • Understanding sexual response cycle • Healthy sexuality • Sexual education	• Complex trauma-related sexual difficulties • Complex medical sexual dysfunction • Persistent or severe erectile dysfunction • Complex pain conditions • Paraphilic disorders (incl. sex addiction) • Gender dysphoria-related sexual concerns • Severe relationship dysfunction • Severe mental health conditions • Cases requiring specialist psychosexual interventions • Compulsive sexual behaviour with risk or offending behaviour • Current domestic abuse • Current self-harm or suicide ideation unless the patient is being supported concurrently by Mental Health Services • Patients requiring language line • Acute addictions requiring therapy

Referrals to the service will only be accepted:

- After all physical causes of the sexual dysfunction have been investigated
- An appropriate treatment plan is in place for contributing organic factors
- The patient is willing to explore own knowledge, emotions and behaviours around sex and sexuality

Please note: A referral does not guarantee an appointment with this service. All referrals will be assessed and if appropriate, will join the waiting list. If your referral is not accepted you will be informed via email, it will be your responsibility to inform the patient. If the individual referred would like more specialist support or specific psychosexual counselling, they may want to access therapy through www.cosrt.org.uk. This will be offered by the service in due course. **Patients cannot self-refer to this service.**

If accepted to the service, the patient will be sent an appointment for a video assessment consultation. Face-to-face appointments are at the discretion of the service provider. Following assessment and if required, further sessions will be arranged. Patients may be referred to other services or directed to other resources to support their needs. If patients miss an appointment, they will be offered one more; if this is missed, they will be discharged.

For further information or advice please contact: eec.icashnorfolksexualwellbeingsservice@nhs.net

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Referral Form

Name of Referrer:	Job Role:								
Referrer Organisation: Contact Tel No: Email (used for correspondence):									
Patient Details (<i>please double check all client details are accurate and up to date</i>): <table> <tr> <td>Title:</td> <td>Name:</td> </tr> <tr> <td>Prefers to be called:</td> <td>D.O.B:</td> </tr> <tr> <td colspan="2">Address:</td> </tr> <tr> <td>Contact Number:</td> <td>Postcode:</td> </tr> </table>		Title:	Name:	Prefers to be called:	D.O.B:	Address:		Contact Number:	Postcode:
Title:	Name:								
Prefers to be called:	D.O.B:								
Address:									
Contact Number:	Postcode:								

Relevant Medical History (incl. mental health):	Medication History (incl. prescribed, OTC, off shelf, vitamins, supplements, recreational):

Referral Criteria

Reason for referral - tick ✓ all relevant and **highlight in bold** primary reason for referral

1. Low or fluctuating desire		2. Arousal difficulties	
3. Situational erectile difficulties		4. Early onset vaginismus / dyspareunia	
5. Performance anxiety		6. Body-image related sexual concerns	
7. Communication difficulties		8. Understanding sexual response cycle	
9. Healthy sexuality		10. Sexual education	

Please give a brief history of the issues experienced by the patient and document any interventions you have already taken (for any dyspareunia please confirm a bimanual / lower abdominal examination has been conducted to rule out Pelvic Inflammatory Disease and / or other physical causes of pain):

Please give details of any other specialists involved in the patient's care or any other referrals that have been made:

Please confirm the patient has had a recent sexual health screen and the results of these (if the patient has not had a sexual health screen, please arrange this prior to referral). If the patient has had any additional tests which are relevant to the reason for referral please list them here with the results. Patients will need to be treated for any positive tests prior to their appointment.

Test:	Date:	Result:	Test:	Date:	Result:
Chlamydia / LGV			Mycoplasma Genitalium		
Gonorrhoea			Genital Herpes		
HIV			Thrush / BV		
Syphilis			Other (Please list below in 'any other information')		

Please give any other information you deem relevant, including any adjustments that may be needed for the patient during their appointment:

Please give relevant information you have about any safeguarding concerns, if applicable:

Signature of Referrer:

Date:

Please return your referral form:

- Via secure email to: eec.icashnorfolksexualwellbeingservice@nhs.net
- For pre-referral case advice please use the secure email (above) and we will get back to you as soon as possible.